Dear Sir or Madam,

Thank you very much for your request for an appointment to be seen in the Fetal Alcohol Spectrum Disorder (FASD) Clinic.

Our goal is to evaluate individuals of all ages at risk for FASD and to provide them appropriate referrals for their care. Clinics are held on Fridays. We are able to see two patients per clinic.

**The next step for you is to complete the attached New Patient Information Form.**

This form will help you and us to prepare for your clinic visit. It must be completed and returned to us before we can schedule your appointment. We realize you may not have all of the information requested on this form. Please do the best you can. Completing the section on maternal use of alcohol (page 8) is especially important. A patient must have a confirmed prenatal alcohol exposure to be seen in our clinic.

Please attach a close-up facial photograph of the patient with no smile.

**Mail the completed New Patient Information Form and the photograph to:**

Susan Astley, Ph.D.  
University of Washington  
CHDD, FAS DPN  
Box 357920  
Seattle, WA 98195-7920

If you have any questions, please contact us at (206) 598-9666 or email us at fasdpn@uw.edu

Sincerely,

Susan Astley Ph.D.  
Director, FAS DPN
New Patient Information Form

FAS Clinic

Patient Identification

Patient's Social Security Number (optional) ___________________________ ☐ Female ☐ Male Race ___________________________

Patient's Name ____________________________________________ Birth date _______________ Age _______________

First Middle Last

Patient's Address ____________________________________________

City __________________________ County ______________ State ______________ zip ________________________

Phone: Home (_____ ) ___________ cell (_____ ) ___________ email ____________________________

Caregiver Identification

Name of patient's primary caregiver(s) ____________________________________________________________

Relationship to patient: ☐ birth, ☐ adoptive, ☐ foster parent, ☐ other (specify ____________________________ )

Caregiver's Address ________________________________________________________________

City __________________________ County ______________ State ______________ zip ________________________

Phone: Home (_____ ) ___________ cell (_____ ) ___________ email ____________________________

Person Completing the Form

Name of person completing this form ____________________________________________ Date ________________________

Relationship to patient: ☐ birth, ☐ adoptive, ☐ foster parent, ☐ caseworker, ☐ medical provider, ☐ ______________

Referred by (person/organization who told you about the clinic) ____________________________

Phone: work (_____ ) ___________ cell (_____ ) ___________ email ____________________________

Who Should Correspondence be Sent To?

Name ________________________________________________________________

Relationship to patient: ☐ birth, ☐ adoptive, ☐ foster parent, ☐ other (specify ____________________________ )

Address ________________________________________________________________

City __________________________ County ______________ State ______________ zip ________________________

Phone: (_____ ) ___________ cell (_____ ) ___________ email ____________________________

Legal Guardian (REQUIRED Information)

Name of patient's legal guardian ____________________________________________

Phone: work (_____ ) ___________ cell (_____ ) ___________ email ____________________________

Guardian's address

City __________________________ County ______________ State ______________ zip ________________________

Guardian’s relationship to patient: ☐ family, ☐ caseworker, ☐ other (specify: ____________________________ )
Please complete this form to the best of your ability. We realize you will not have the answers to all questions. All information requested in this form is important in allowing us to provide you with the most accurate diagnosis and most appropriate referrals for care. Thank you for taking the time to complete it.

**Reasons for Evaluation**  What are the patient's primary problems? Please be specific.

________________________________________________________________________

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What do you hope to gain from the evaluation?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Growth

Birth Measures

1. Birth weight: lbs / oz _______________ or gms _______________
   Birth length: inches _______________ or cm _______________
   Birth head circumference: inches _______________ or cm _______________
   Gestational age (length of pregnancy): weeks _______________ or months _______________

Please provide additional height, weight and head measures if available*

2. Date _______________ Weight: lbs _______________ or kg _______________
   Age _______________ Height: inches _______________ or cm _______________
   Head Circumference: inches _______________ or cm _______________

3. Date _______________ Weight: lbs _______________ or kg _______________
   Age _______________ Height: inches _______________ or cm _______________
   Head Circumference: inches _______________ or cm _______________

4. Date _______________ Weight: lbs _______________ or kg _______________
   Age _______________ Height: inches _______________ or cm _______________
   Head Circumference: inches _______________ or cm _______________

5. Date _______________ Weight: lbs _______________ or kg _______________
   Age _______________ Height: inches _______________ or cm _______________
   Head Circumference: inches _______________ or cm _______________

Birth Parents’ Heights:
   Birth Mother: inches _______________ or cm _______________
   Birth Father: inches _______________ or cm _______________

* This information may be available from the patient's physician or school nurse. If growth charts are available and can be photocopied and attached to this form, you need not fill out this section.
Physical Appearance and Health

1. **Photographs of the patient’s face are very helpful to us.** The best photos are ones where the face fills the photo and the patient is not smiling. Pictures between ages 1 and 12 years are best.

   - Are such photographs available? ____ yes ____ no
   - Are one or two included with this form? ____ yes ____ no
   - Can others be brought to the clinic? ____ yes ____ no

   Please staple photo(s) here:
   
   Photo may be bigger than this space

2. **Was the patient born with (or later discovered to have) any birth defects (things like cleft lip, congenital heart defects, club foot, etc.)?** ____ yes ____ no _____ unknown

   If yes, please describe: ______________________________________________________
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________
   _______________________________________________________

3. **Has this patient ever had:**

<table>
<thead>
<tr>
<th>Allergies</th>
<th>yes</th>
<th>no</th>
<th>unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple ear infections</td>
<td></td>
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<tr>
<td>Chronic sinusitis</td>
<td></td>
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<tr>
<td>Chronic hearing loss</td>
<td></td>
<td></td>
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<tr>
<td>Visual problems</td>
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</tbody>
</table>

   | Chronic illness of the heart | yes | no | unknown |
   | Chronic illness of the kidneys |     |    |         |
   | Chronic illness of the joints/limbs |     |    |         |
   | Chronic illness of the stomach/bowels |     |    |         |

4. **Has this patient ever had:**

   A. **Operations (since birth)** ____ yes ____ no ____ unknown

      Describe Operation
      _____________________________

      Surgeon’s Name
      _____________________________

      Patient’s Age
      _____________________________

   B. **Any other hospitalizations** ____ yes ____ no ____ unknown

      Reason for Hospitalization
      _____________________________

      Hospital/Doctor
      _____________________________

      Patient’s Age
      _____________________________

   C. **Physical abuse** ____ yes ____ no ____ unknown

      Was this evaluated by a physician? ____ yes ____ no ____ unknown

   D. **Sexual abuse** ____ yes ____ no ____ unknown

      Was this evaluated by a physician? ____ yes ____ no ____ unknown
Neurological Issues

1. Has this patient ever had:
   
   A. Seizures
   
   ____ yes     ____ no     ____ suspected     ____ unknown
   
   Type: ____________________________________________________________
   
   Age when seizure(s) started: ______________________________________
   
   Name(s) of medication(s) given? ____________________________________
   
   B. Loss of specific motor skills such as standing, walking, running, etc.
   
   ____ yes     ____ no     ____ unknown
   
   If yes, please describe ____________________________________________
   
   C. Bed wetting or soiling after 8 years of age.
   
   ____ yes     ____ no     ____ unknown     ___ not 8 years old yet
   
2. Has this patient ever had a head injury leading to unconsciousness or evaluation by a doctor?
   
   ____ yes     ____ no     ____ unknown
   
   If yes, please describe ____________________________________________
   
3. Has the patient ever had a CT scan or MRI scan of the brain
   
   ____ yes     ____ no     ____ unknown
   
   If yes, was it described to be abnormal?     ____ yes     ____ no     ____ unknown

Attention Deficit and Hyperactivity

1. Has the patient ever been evaluated for attention deficit/hyperactivity disorder (ADD / ADHD)
   
   ____ yes     ____ no     ____ unknown
   
   If yes:
   
   When was the evaluation done?    Age: ______________________    Date: ______________________
   
   Was the patient diagnosed with ADD or ADHD?     ____ yes     ____ no     ____ unknown
   
   Was the patient ever treated for ADD or ADHD?     ____ yes     ____ no     ____ unknown
   
   What medications have been tried?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Ages</th>
<th>Response</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Mental Health Issues

1. Has the patient ever been evaluated by a psychiatrist, psychologist, or MH counselor?
   ____ yes  ____ no  ____ unknown

   If yes, please list each psychiatrist, psychologist and/or counselor.

   A. Type of professional: _____________________________________________________________
      Reason for assessment: ____________________________________________________________
      Type of therapy (i.e., behavioral, individual counseling, group counseling, family counseling, medicine): ____________
      Age at the time of therapy: ____________ Did the therapy help?  ____ yes  ____ no  ____ unknown
      If yes, how did it help? ____________________________________________________________

   B. Type of professional: _____________________________________________________________
      Reason for assessment: ____________________________________________________________
      Type of therapy (i.e., behavioral, individual counseling, group counseling, family counseling, medicine): ____________
      Age at the time of therapy: ____________ Did the therapy help?  ____ yes  ____ no  ____ unknown
      If yes, how did it help? ____________________________________________________________

2. Has the patient ever been evaluated for mood problems (depression, anxiety, etc.) or phobia?
   ____ yes  ____ no  ____ unknown

   If yes:
   When was the evaluation(s) done? Age(s): ________________ Date(s): ________________

3. What medications have ever been tried and how well did they work?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Response</th>
<th>Currently Using?</th>
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</thead>
<tbody>
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</tbody>
</table>
## School Issues

1. List **ALL** schools the patient has attended and the grades of attendance:

<table>
<thead>
<tr>
<th>School</th>
<th>City</th>
<th>Grades Attended</th>
<th>Received Special Education, Resource Room, Tutoring, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>yes  no  unknown</td>
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</table>

2. What **learning** problems does the patient have?

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

3. What **behavioral** problems does the patient have?

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
Alcohol Exposure

Please fill in this information as completely as possible.
A confirmed history of alcohol use during this pregnancy is required for an appointment.

Alcohol use by the birth mother

● Before pregnancy: average number of drinks per drinking occasion: ____________________
  maximum number of drinks per occasion: ____________________
  average number of drinking days per week: ____________________
  Type(s) of alcohol: ___wine, ___beer, ___ liquor, ___ unknown, ___ other (specify) __________

● During pregnancy: average number of drinks per drinking occasion: ____________________
  maximum number of drinks per occasion: ____________________
  average number of drinking days per week: ____________________
  Type(s) of alcohol: ___wine, ___beer, ___ liquor, ___ unknown, ___ other (specify) __________

Which trimester(s) did the mother drink alcohol? ___1st ___2nd ___3rd ___unknown

Was the birth mother ever reported to have a problem with alcohol? ___ ___ ___

Was the birth mother ever diagnosed with alcoholism? ___ ___ ___

Did the birth mother ever receive treatment for alcohol addiction? ___ ___ ___

If the above information is unknown, please provide any information that may help describe the mother’s level of alcohol use during this pregnancy, not before or after this pregnancy.

________________________________
________________________________
________________________________

What is the source(s) of this information on alcohol use? __________________________________

________________________________

Did the birth mother use any of the following substances during pregnancy?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>Type</th>
<th>Please List Specific Substance(s)</th>
<th>Month(s) of Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
<td>___</td>
<td>Drugs</td>
<td>________________________________</td>
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<td>___</td>
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<td>Tobacco</td>
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<td>Medications</td>
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<td>___</td>
<td>___</td>
<td>X-rays</td>
<td>______________________________</td>
<td>___</td>
</tr>
</tbody>
</table>
Information about the Patient's Biological Parents

**Birth mother's name**  
First: ____________________  Middle: ____________________  Last: ____________________  
Birth date ____________________
  
Mother's Race  
☐ White  ☐ Black  ☐ American Indian  ☐ Alaskan Native  ☐ Hispanic  
☐ Asian  ☐ unknown  ☐ other (specify) ____________________
  
Education level attained (last year of school completed) ____________________  Age at birth of patient _______
  
Does she have a history of learning problems? ____________________
  
Birth mother's Address  
Street: ____________________  City: ____________________  State: ____________________  Zip: ____________________
  
When was the last contact with the birth mother? ____________________

**Birth father's name**  
First: ____________________  Middle: ____________________  Last: ____________________  
Birth date ____________________
  
Father's Race  
☐ White  ☐ Black  ☐ American Indian  ☐ Alaskan Native  ☐ Hispanic  
☐ Asian  ☐ unknown  ☐ other (specify) ____________________
  
Education level attained (last year of school completed) ____________________  Age at birth of patient _______
  
Does he have a history of learning problems? ____________________
  
When was the last contact with the birth father? ____________________

Medical History of the Biological Family

Has anyone in this patient's biological family ever had any of these conditions? *Check all that apply.*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Birth Mother</th>
<th>Birth Father</th>
<th>Mother's Family</th>
<th>Father's Family</th>
<th>Siblings of patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
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<tr>
<td>Birth Defects</td>
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<tr>
<td>Stillbirths</td>
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<td>Miscarriages</td>
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<tr>
<td>Mental retardation</td>
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<tr>
<td>Other developmental disabilities</td>
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<td>Learning disorders</td>
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<td>Attention deficit</td>
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<td>Hyperactivity</td>
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<td>Epilepsy</td>
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<td>Neurological disease</td>
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<td>Child abuse</td>
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<tr>
<td>Sexual abuse</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Suicide</td>
<td></td>
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<td>Mental illness</td>
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<td>Vision problems</td>
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<tr>
<td>Hearing problems</td>
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<tr>
<td>Chronic illnesses</td>
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<tr>
<td>Tourette syndrome</td>
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<tr>
<td>Delinquency</td>
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<tr>
<td>Any specific genetic condition</td>
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<td>Other</td>
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</tbody>
</table>
# Pregnancies of Birth Mother

1. Please list **all** of the birth mother’s pregnancies including miscarriages, abortions, in the order of their occurrence:

<table>
<thead>
<tr>
<th>Year</th>
<th>Length of Pregnancy</th>
<th>First name of child if applicable</th>
<th>Live born Child</th>
<th>Normally Developed</th>
<th>If not normal, please explain</th>
<th>Include FAS / FAE diagnosis, if known</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<td></td>
<td></td>
<td></td>
<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<td></td>
<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<tr>
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<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Live born Child</td>
<td>Normally Developed</td>
<td>If not normal, please explain</td>
<td>Include FAS / FAE diagnosis, if known</td>
</tr>
</tbody>
</table>

**Office Use:**

<table>
<thead>
<tr>
<th>Total Parity</th>
<th>Total Gravity</th>
<th>Patient Parity</th>
<th>Patient Gravity</th>
<th>FASD diagnoses</th>
</tr>
</thead>
</table>

# Pregnancy, Labor, and Delivery of this Patient

1. **Did the birth mother experience any difficulties during pregnancy?**  
   _Yes_  _No_  _Unk_.
   If yes, please describe: ________________________________________________________________

2. **Did the birth mother receive prenatal care?**  
   _Yes_  _No_  _Unknown_

3. **Were there complications during the labor or delivery?**  
   _Yes_  _No_  _Unknown_.
   If yes, please explain: ________________________________________________________________

4. **Was the delivery:**  
   _Natural_  _By C-section_  _Unknown_.

5. **Where was patient born?**
   Hospital Name ________________________________________________________________
   City ____________________________ State ____________________________

6. **APGAR scores:**
   (at 1 minute ________)  (at 5 minutes ________)  (at 10 minutes ________)

7. **How many days did the infant stay in the birth hospital?** ________________________________

8. **Did the patient have any of the following problems while still in the birth hospital?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
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<tbody>
<tr>
<td>Feeding problems</td>
<td></td>
<td></td>
<td></td>
<td>Infections</td>
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<tr>
<td>Apnea / breathing difficulties</td>
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<td></td>
<td></td>
<td>Jaundice</td>
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<tr>
<td>Supplemental oxygen required</td>
<td></td>
<td></td>
<td></td>
<td>Convulsions</td>
<td></td>
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</table>
### List of Professionals Currently Involved in Patient’s Care

<table>
<thead>
<tr>
<th>Professional Type</th>
<th>Name</th>
<th>Phone</th>
<th>Address</th>
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<tbody>
<tr>
<td><strong>Primary Physician</strong></td>
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<tr>
<td><strong>Other Physicians</strong></td>
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<tr>
<td><strong>Mental Health</strong></td>
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<tr>
<td><strong>Consultants</strong></td>
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<tr>
<td><em>(includes Psychiatrists, Psychologists, and Counselors)</em></td>
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<tr>
<td><strong>School</strong></td>
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<tr>
<td><strong>Other</strong></td>
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### Placements

1. **List all of the placements the patient has had from birth through today.**

<table>
<thead>
<tr>
<th>Type of placement (i.e., foster, adoptive, etc.)</th>
<th>Duration of placement</th>
<th>Age of patient when placement started</th>
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**Office Use:**

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<th>Total</th>
<th>First</th>
<th>Last</th>
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</table>

**A. How long has the patient been in your care?** ________________

### What to bring to Clinic

If the patient has had any of the following assessments, please bring them to Clinic on the day of your appointment. This information is very important to the patient's diagnostic evaluation.

- _____ Facial photographs of the patient from birth to 12 years of age, without a smile.
- _____ Medical records which document the problems you have reported above.
- _____ School Assessments including:
  - Achievement tests
  - IQ tests
  - Language assessments
  - Social Skills assessments
  - Behavior assessments
- _____ Psychological Assessments
- _____ Developmental Assessments including:
  - Motor Development (fine and gross motor)
  - Occupational Therapy assessments
  - Mental (cognitive) assessment